GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

NEW LICENSE APPLICATION
BOARD OF MASSAGE THERAPY

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at **1-877-672-2174**, Monday through Friday, 8AM to 4PM EST. **A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)**

Section 1. REQUEST LICENSE TYPE/FEES

☐ MT - Massage Therapist by Examination		$176.00
☐ MT - Massage Therapist by Endorsement		$176.00
☐ Duplicate Licenses (limit 5)	X$26.00=	$ 0.00
Total Enclosed		$ 0.00

Make check or money order payable to Promissor

Mail To:
Department of Health
Health Professional Liscencing Adminstration
Board of Massage Therapy
717 14th Street, NW
Suite 600
Washington, DC 20005

Walk-in Service
Monday through Friday, 9 to 4 EST
717 14th Street, NW
Suite 600
Washington, DC 20005

HPLA ONLY		
Check $	Check #	Staff

Section 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you attended college or university, please complete Section 4 on page 2. You must also provide legal name change document for EACH time thatit has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court oders.

First Name	Last Name	MI	Suffix (Jr, Sr, etc.)

Social Security Number	Date Of Birth (mm/dd/yyyy)
Place Of Birth	◯ Male ◯ Female Gender Please Check the Correct Box

Section 3. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ○ Marriage ○ Divorce ○ Court Order ○ Spouse Death Certificate

First Name | MI | Last Name | Suffix (Jr, Sr, etc.)

Changed to current name by: ○ Marriage ○ Divorce ○ Court Order ○ Spouse Death Certificate

First Name | MI | Last Name | Suffix (Jr, Sr, etc.)

Changed to current name by: ○ Marriage ○ Divorce ○ Court Order ○ Spouse Death Certificate

First Name | MI | Last Name | Suffix (Jr, Sr, etc.)

Changed to current name by: ○ Marriage ○ Divorce ○ Court Order ○ Spouse Death Certificate

First Name | MI | Last Name | Suffix (Jr, Sr, etc.)

Section 4A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable. ZIP code should correspond to the PO Box number.

○ Apartment ○ Suite ○ Floor ○ PO Box 0

Building Number

Street Address 1

Street Address 2

City

State

Zip Code + 4

Phone

Fax

Email

Section 4B. BUSINESS ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable. ZIP code should correspond to the PO Box number.

Company Name

◯ Apartment ◯ Suite ◯ Floor ◯ PO Box

0

Building Number

Street Address 1

Street Address 2

City

State

Zip Code + 4

Phone

Fax

Email

Section 4C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

◯ Home ◯ Business

Section 5A. PROFESSIONAL SCHOOLS ATTENDED

List all nursing schools that you have attended, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certification

Section 5B. POSTGRADUATE EXPERIENCE

List all experience since graduation from school, in reverse chronological order, beginning with the most recent.

Organization/Institution	Location	Start Date	End Date	Type of Position (Use Key Below*)	Full Time	Part Time

* TYPE OF POSITION KEY
A. Employment
B. Internship
C. Private Practice
D. Clinical Rotations
E. Other (specify on separate sheet of paper)

Section 5C. PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a license. Provide letters of verification from original and current jurisdictions (if different).

Jurisdiction	Date License Was First Obtained	License Number

Section 3. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included in this package or requested to be sent to the Board of Massage Therapy. Keep a photocopy of all supporting documents for your records.

			HPLA ONLY
A.	Two recent passport-type photos of the applicant's face (approx. 2" X 2") with applicant's name printed on the back. Home snapshots or computer photographs are not acceptable.	Yes ○ No ○	☐
B.	Official transcript (with seal) from EACH approved or accredited institution. May be sent directly from the school, but it is preferred that it accompany the application in a sealed envelope.	Yes ○ No ○	☐
C.	National Certification Examination for Therapeutic Massage and Bodywork, Inc. (NCETMB) score report or another examination's results certified by the National commission of Certifying Agencies (NCCA) and approved at the discretion of the Board.	Yes ○ No ○	☐
D.	If you are or have ever been licensed in another state/jurisdiction: Verification of State Licensure from EACH jurisdiction.	Yes ○ No ○	☐
E.	Copies of legal documents supporting all name changes.	Yes ○ No ○	☐
F.	If educated in foreign country and the documents necessary to evaluate applicant's practical training and education are not in English: Applicant shall arrange for translation of said documents into English.	Yes ○ No ○	☐

Section 7. QUESTIONS Applicants MUST answer all of the following questions

Please answer questions A through K by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through K below, you must provide full information and complete details on a separate sheet of paper, including copies of all relevant court documents, and attach to this form.

			HPLA ONLY
A.	**Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.** Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke the license or permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to DC Official Code § 47-2864 (2001). IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED. As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia government as a result of any of the following: Fines, penalties, or interest assessed pursuant to DC Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985) Fines or interest assessed pursuant to DC Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994) Fines, penalties, or interest assessed pursuant to DC Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985) Past due taxes Past due District of Columbia Water and Sewer Authority service fees Fines or penalties assessed pursuant to DC Official Code Title 50, Chapter 23 (Traffic Adjudication) The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the Clean Hands Before Receiving a License or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).	Yes ○ No ○	
B.	Have you ever been convicted of or investigated for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	Yes ○ No ○	☐
C.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	Yes ○ No ○	☐
D.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	Yes ○ No ○	☐

E.	Has any authority taken adverse action against your license or privileges or informed you of any pending charges not previously reported to this board?	Yes ○ No ○	☐
F.	Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?	Yes ○ No ○	☐
G.	Have you ever been terminated from or resigned from a clinical or professional training program?	Yes ○ No ○	☐
H.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	Yes ○ No ○	☐
I.	Within the last ten (10) years, have you been treated for alcohol abuse, controlled substance abuse, prescribed medication abuse, or illegal drug abuse?	Yes ○ No ○	☐
J.	(1) Have you withdrawn an application (in DC or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	Yes ○ No ○	☐
K.	Have you ever been terminated due to practice issues or behavioral issues since obtaining your (professional) license within the last ten (10) years?	Yes ○ No ○	☐

Section 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

APPLICANT SIGNATURE	NAME (please print)	DATE	HPLA ONLY
			☐

To report waste, fraud, or abuse by any DC government office or official, call the DC Inspector General at 1-(800)-521-1639.